

National and State Impacts of the Medicare Prescription Drug Conference Proposal

*A Senate Health, Education, Labor and Pensions Committee
Minority Staff Analysis*



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This analysis examines the impact of the conference proposal on the nation and on each state. In brief, it finds the program includes provisions that will have the effect of privatizing Medicare and forcing senior citizens into HMOs and other private insurance plans. Other provisions of the proposal mean that millions of senior citizens and Americans with disabilities currently covered by Medicare would actually find themselves worse off if the conference report becomes law. Finally, the proposal creates an unlimited program of Health Savings Accounts (HSAs). This tax break benefits the healthy and wealthy and could dramatically raise health insurance premiums for other Americans—particularly families with moderate incomes and those with high health expenses.

Privatization of Medicare through “premium support” and excessive government subsidies to HMOs and the insurance industry

Premium Support

The conference report includes a large “demonstration” of a program called “premium support” that will have the effect of pricing senior citizens out of Medicare and forcing them to join HMOs or other private insurance plans to get affordable coverage. Currently, Medicare beneficiaries pay a fixed, national premium for coverage under Part B of the program, the part that pays for doctor and other outpatient costs. The government pays 75% of the costs of Part B and beneficiaries pay the remaining 25%.

Under premium support, the beneficiary premium is no longer fixed and national. Instead, it becomes a different amount in each area, based on the weighted average of Medicare costs and the costs of HMOs and other private insurance plans in that area. HMOs cut corners and ration care in ways that Medicare does not—for example, by restricting access to physicians and hospitals, enrolling healthier people, and competing with Medicare in areas where Medicare costs are high. As a result, the weighted average calculation requires the government to pay a lower percentage of the cost of Medicare than under current law in most cases. This means that Medicare premiums rise.

Initially, the effect of the premium support program would raise premiums in Medicare an average of 25%, according to the Medicare actuary.¹ But the surcharge to stay in Medicare could rapidly grow as healthier people increasingly leave Medicare for the private sector, creating an insurance “death spiral.”² Moreover, the premiums seniors have to pay could vary dramatically, depending on where they live. According to the Medicare actuary’s estimates, Medicare premiums could range from a high of \$2,400 in Jefferson Parish, Louisiana, to a low of \$675 in Davidson County, North Carolina. Variations within each state can be almost as large and are displayed in the fact sheets for individual states included in this book.

Beginning in 2010, the proposed conference agreement establishes a six-year premium support “demonstration” in six metropolitan statistical areas of the country, to be chosen by the Secretary of Health and Human Services. One of the areas chosen must be sparsely populated. For a metropolitan statistical area to qualify for the demonstration, twenty-five percent of the senior citizens in that region must be enrolled in private plans. Forty-one MSAs currently meet the 25% test. By 2010, given the large additional subsidies provided to private plans under the bill, almost seven million senior citizens and disabled—one in six Medicare beneficiaries--could be forced into the premium support program.³ Areas in more than half the states in the country are potential sites for the demonstration. The fact sheets show which areas could be included in the demonstration in each state.

Not only does the demonstration subject six million or more senior citizens to premium support, but it provides the basis for quick movement to premium support everywhere. Once the program is established in law, it would be easy for a subsequent Congress to lower the threshold for participation or eliminate the limitation on the number of regions or local areas participating and establish premium support everywhere.

Excessive subsidies to HMOs and private insurance

Rather than establishing fair competition and real choices for senior citizens, the proposed conference report tilts the deck against Medicare by providing heavy additional subsidies for private insurance plans. These subsidies make Medicare less affordable relative to HMOs, raise government costs, and hasten the depletion of the Medicare Trust fund. Because they raise government costs, they increase the premiums of senior citizens.

- PPO “stabilization” fund. The Senate bill provided an additional \$6 billion for PPOs balanced by an additional \$6 billion for Medicare enhancements. The proposed conference agreement provides \$12 billion in extra subsidies for PPOs and nothing for Medicare enhancements.
- Inflated premium to HMOs and PPOs. The proposed agreement adopts the revisions in the payment formula contained in the House bill. This raises average payments to Medicare private plans to 109% of Medicare costs. This places an unfair competitive disadvantage on Medicare and raises Medicare costs a minimum of nine percent for each person who joins an HMO or PPO.
- Adverse selection. CMS’s own data show that senior citizens who enroll in Medicare HMOs have costs that are 16% below those of those in conventional Medicare, solely because they are in better health.⁴ Combined with the other features of the proposed conference agreement, private sector plans will be overpaid a minimum of 25%.

Millions of senior citizens and disabled Medicare beneficiaries will be worse off

Loss of private retiree coverage

The conference agreement discriminates against senior citizens with employer-sponsored retiree plans by providing a lesser government contribution to their benefits than to other senior citizens. No other Medicare benefit is provided in this discriminatory way. As a result of this structure, CBO estimated that large percentages of senior citizens with employer-sponsored retiree coverage could lose it. Under the proposed conference agreement, approximately 21% of retirees (2.5 million) would lose coverage.⁵

The state analyses in this report show how many retirees in each state would lose their coverage.

Medicaid Beneficiaries

The proposal establishes a uniform Federal standard for drug co-payments for low income beneficiaries covered under both Medicare and Medicaid. The proposal indexes these co-payments, bars states from filling in the co-payments for these dual eligibles with both Medicaid and Medicare coverage, and prohibits states from establishing more expansive formularies for the mentally ill, disabled, and other groups. The result is that the proposed agreement actually makes six million poor aged and disabled Medicaid beneficiaries worse off: their out-of-pocket expenses will be higher and their access to needed drugs will be reduced. Studies have shown that even very small co-payments for prescription drugs can make essential medicines unaffordable for low-income seniors, resulting in an 88% increase in hospitalization and deaths and a 78% increase emergency room visits.⁶

The state analyses show how many Medicaid beneficiaries will be forced to pay more for their drugs in each state.

Assets test

The bipartisan Senate bill would have provided comprehensive drug coverage for nine million senior citizens, in addition to those currently covered under Medicaid, through an enhanced low income benefit. The bill allowed low income seniors to receive this benefit without being subjected to a harsh and demeaning assets test. The agreement reinstates the assets test and lowers the income eligibility level. More than three million low income senior citizens would be denied access to enhanced benefits.⁷

The state analyses show how many low income seniors are denied access to special assistance as a result of this provision in each state.

Means-related premium

The legislation establishes a means-related premium for the Part B benefit, beginning in 2007. Approximately 1.6 million senior citizens (4.5 percent) with incomes over \$80,000 would pay a higher premium as a result.⁸ There was no comparable provision in either bill. Medicare is already progressively financed, and a means-related premium could undermine the broad support the program enjoys from senior citizens of all income levels. The state analyses show how many senior citizens will be forced to pay a higher premium in each state as the result of this provision.

Discriminatory Budget Cap for Medicare

The proposal establishes in law an arbitrary standard for Medicare expenditures and creates a new mechanism for the forced discharge from committee of legislation to achieve this standard. The proposal would require a Presidential recommendation on cutting Medicare funding and require expedited consideration of Medicare cuts in the Senate if the general revenue share of Medicare expenditures was projected to exceed 45% in seven years. This provision establishes a congressionally endorsed Medicare spending target that has no relation to the needs of the elderly or the cost of medical care.

Drug Prices

The proposal for drug reimportation is weaker than the legislation passed by either the Senate or the House.

Health Savings Accounts

Health Savings Accounts were previously called Medical Savings Accounts. They make it possible to buy a high deductible account and to put money to pay some or all of the cost of deductible into a tax free account similar to an IRA. The proposal eliminates the limits on such accounts included in the 1996 Health Insurance Portability and Accountability Act, makes permanent what had been a time-limited demonstration, and makes other changes to the accounts, such as allowing tax-free contributions to equal 100% of the deductible. These accounts help the healthy and wealthy and certain insurance companies, but are bad for most Americans, especially the Americans with lower incomes or those in ill health. Estimates by the Urban Institute, the American Academy of Actuaries, and others indicated that these accounts could raise premiums for comprehensive coverage as much as 60%.⁹

**Impact of Medicare Prescription Drug Conference Proposal on
Nevada Senior Citizens:
Medicare at Risk
Too Many Senior Citizens and Disabled Persons Worse Off**

Medicare at Risk

- ∞ 1 MSA in Nevada could be selected for the premium support demonstration program, and another MSA is close to meeting the qualifying threshold.¹ In total, 237,156 Medicare beneficiaries reside in MSAs that could be chosen for premium support.

Qualifying MSAs:
Las Vegas-Paradise

MSAs that could qualify by 2010:
Reno-Sparks

- ∞ Premium variation under a full-blown premium support program could range from \$1,950 in Clark to \$1,250 in Lyon.²

Senior Citizens and Disabled Persons Worse Off

- ∞ 14,490 Medicare beneficiaries in Nevada will lose their retiree health benefits.³
- ∞ 19,700 Medicaid beneficiaries in Nevada will pay more for the prescription drugs they need.⁴
- ∞ 18,500 fewer seniors in Nevada will qualify for low-income protections than under the Senate bill because of the assets test and lower qualifying income levels.⁵
- ∞ 9,920 Medicare beneficiaries in Nevada will pay more for Part B premiums because of income relating.⁶

(Footnotes)

¹ Calculations based on CMS HMO participation data. MSAs that currently have 25% or more HMO penetration were considered qualifying; MSAs that could qualify by 2010 based on HMOs with current penetration rates of 15% or more.

² CMS Actuary.

³ Current levels of state employer-sponsored insurance from K.Thorpe, "Potential Implications of the Medicare Prescription Drug Benefit on Retiree Health Care Benefits" September 13, 2003. Drop rate based on CBO estimates.

⁴ Calculations based on the number of dual eligibles in state, Congressional Research Service Report RL31987, July 11, 2003. Nevada currently has no drug copayment.

⁵ Calculations based on income data from Congressional Research Service Report RL31736, June 24, 2003; CBO estimates on loss of coverage due to assets test.

⁶ Calculations based on data from Congressional Research Service Report RS21651, October 28, 2003.